threat of job loss. This coercion may sometimes be denied or minimised by those advocating and implementing the policy. It is invariably accurately recognised as such by the employee. When a company referral, by definition linked with disciplinary procedures and threat of job loss, is made, communication between employer and employee may be less than frank. As a medical adviser I have found myself put in the position of referee in a game played between employer and employee in as much as an employee may be merely "going along with" referral to avoid disciplinary action. Despite this, my experience suggests that the use of disciplinary procedures can be an effective way of motivating some individuals to change their drinking habits. The final decision, however, is that of the individual concerned. It is important that this is recognised by all parties.

Following our experience a number of other companies in Glasgow are at present introducing alcohol-dependency policies. I feel that such policies warrant more extensive evaluation. In attempting to do this I have put forward a proposal to evaluate the changes, in a representative sample of employees, in drinking behaviour and attitudes to drinking before and after the introduction of one such policy. This study would evaluate the broader aims—(*a*) and (*b*) outlined above—of such policies.

Despite the lack and need of such a study it was felt by the company, in consultation with other agencies, that such a study might jeopardise the introduction of the policy. Particular reservations were expressed about the reaction of the unions to such a study, although in this case the unions were not consulted about it. This demonstrates some of the difficulties that may be encountered when one is trying to investigate objectively in this field.

It is my opinion that it is important to establish the efficacy of such policies before they are introduced in Britain in wide measure. There is a pressing need to identify which approaches to the prevention of alcohol problems are useful so that effort and resources can be channelled in the right direction.

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Let's abolish "the elderly"

SIR,—There is a curious predilection among the authors of papers, which is presumably shared by editors, for inclusion of the words "the elderly" in the title of otherwise admirable articles. This derives from and lends support to the view that there is a homogeneous mass of people whose only characteristic is that they are somewhat older than ourselves, and about whose behaviour general inferences can be drawn.

I have previously had occasion to express my disapproval of the use of this term by the authors of an article in your journal who, it transpired from the text, were referring to people aged 50 and over. Lest you might think this represents personal sensitivity may I point my criticism in the other direction and refer to the article on blood pressure reduction "in the elderly" (31 October, p 1151)? It turned out that these subjects were all residents of local authority welfare homes with a mean age of 80. Residents of homes comprise 2% of those who are conventionally looked upon as "the elderly"—that is, those aged 65 and over. I have no quarrel with the findings or with their interpretation; but if the authors and the editors do not wish these findings to be extrapolated to other and quite different groups of old people they should specify the subject group more precisely in the title.

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Survey of sickle-cell disease in England and Wales

SIR,—In their survey of sickle-cell disease in England and Wales Dr L R Davis and colleagues (5 December, p 1519) have indicated that the figure of 1367 for 1978-9 probably "may represent only half the total number of cases." I think that what they reveal in their excellent article is the tip of a colossal iceberg of a problem, which calls for the following observations.

(1) Using only haematologists as they do, the authors may merely be emphasising some aspect of "hospital incidence." Many adult patients with genuine sickle-cell anaemia of the SS variety may be symptomless for several years, and patients with haemoglobin SC disease for decades. Of 377 consecutive patients with Hb SC disease in the steady state no less than 154 (41%) had haemoglobin levels of 12·0 g/dl or more.[1] For West Africans with 20% sickle-cell trait and 10% HbC trait incidence in the population the phenotypes SS and SC each occur once in every 100 births. For every identified SC patient in Britain there are many who are not known, and one argument in favour of voluntary mass screening is that it could unearth the hundreds of cases of SC sickle-cell disease, some of whom are breadwinners, before they are brought in dying or dead in their first crisis for 10 years.

(2) Many known patients with the SC phenotype are treated directly by ophthalmologists and other clinicians without the intervention of a haematologist, so they will have been missed by the survey.

(3) Some general practitioners are seeing an increasing number of sickle-cell crises in patients whose phenotypes they already know, and many crises are dealt with in casualty departments and the patients discharged the same day.

(4) Quite apart from numbers, which must surely exceed the 4000 cases of haemophilia and even the cases of phenylketonuria and cystic fibrosis put together, the mechanics of tackling the sickle-cell disease problem in Britain are far less defined than in the United States. This may be one explanation of the authors' comment that while "these other inherited disorders are expensive to treat, . . . superficially sickle-cell disease would appear to be much less so." In my opinion, unless the sickle-cell disease problem is tackled comprehensively in this country (which may, of course, make it as expensive to treat as the above-mentioned hereditary diseases) the mortality indicated in the article and the degree of morbidity patients are going to be left with (28 organs and tissues liable to infarction)[1] will prove even more frightening.

(5) The responsibility for such a comprehensive approach cannot be left with the central government alone. Local councils with active participation of parents, community leaders and businessmen, self-help groups, local medical and nursing personnel, community social workers,[2] and where necessary adult patients must together be involved with "centres" on the lines recommended by WHO.[3] Medical personnel should be alert to the problem as "mortality and morbidity could be reduced . . . by more active treatment of seemingly minor illness."[4]

(6) The advantage of "centres" is that danger signs can be quickly discerned on regular visits and older patients can be extremely useful. I have seen adult patients working in some of these centres succeed (where doctors have failed) in convincing fellow patients and relatives of the value of regular clinic attendance, genetic counselling, and the limitation of family size.[5]

Dr Davis and his colleagues say that in several instances "the haematologist wishes to see the patients regularly but the patients were not always willing to attend." In my experience this would be because the patients did not feel they were benefiting. If in addition to the usual "How are you?" and the blood test and folic acid estimation the clinician went on to look at the legs for ulcers, measured liver size, inquired about games at school, asked whether periods had begun, and checked how many holes there were in the teeth the patients would surely come back. SERVICE, Education, research—in that order of priority—will guarantee patients' co-operation but reversing the order, as often happens, to RESEARCH, Education, service succeeds in driving some away.

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[1] Konotey-Ahulu FID. *Arch Intern Med* 1974;**133**:611-9.
[2] Anioniwu E, Walford D, Brozovic M, Kirkwood B. *Br Med J* 1981;**282**:283-6.
[3] World Health Organisation. *Treatment of haemoglobinopathies and allied disorders*. Geneva: WHO, 1972: 1-83. (Technical Report Series No 509).
[4] Murtaza LC, Stroud CE, Davis LR, Cooper DJ. *Br Med J* 1981;**282**:1048-51.
[5] Konotey-Ahulu FID. *Br Med J* 1980;**281**:1700-2.

SIR,—I have read with interest the article "Survey of sickle-cell disease in England and Wales" (5 December, p 1519). I worked in Zambia, Central Africa, for about six and a half years from 1974 and wish to add my observations on sickle-cell disease.

Briefly, the African pattern of sickle-cell disease is almost same as in the West Indies except for some genetic differences. The Africans south of the Sahara have a high incidence of sickle-cell and of cDe genes and a low incidence of MN genes. The clinical manifestations in 19 homozygotes were as follows: leg ulcer—1 case; osteomyelitis—3; infarction of femoral head—1; bronchopneumonia—4; pathological fracture—1; dactylitis—3; sequestration crisis—2; haemolytic crisis—2; abdominal crisis—2. The earliest age of clinical detection was 3 months. Between the ages of 3 months and 2 years the children came with jaundice, dactylitis, bronchopneumonia and from 2 to 6 years with severe anaemia, osteomyelitis, and bronchopneumonia; over the age of 6 the patients were seen more frequently with abdominal crisis, severe bone and joint pains, palpitation, and evidence of congestive cardiac failure. Cases with central nervous system complications and haematuria were not seen, and leg ulcers were very rarely seen. The type A meningococcal meningitis so common in central Africa was not a common complication of sickle-cell anaemia. The same patient was admitted with different organs affected on different occasions. Only one patient was admitted on many occasions with osteomyelitis of different bones and bilateral pathological fractures of the femur.

Prophylactic folic acid and penicillin were of no value in reducing the frequency of crisis. The only measure that seemed to be of some benefit was partial exchange transfusion, but the patients and relatives constantly refused this procedure.

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